ATTACHMENT 5

PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Im A

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow St.
Anytown, WI 55555

5 DATE OF BIRTH
MM/DD/YY

6 SEX
M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX)XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE
I.M. Billing
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
12345678

10 DX: PRIMARY
V537

11 DX: SECONDARY

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6635		3	P	Ischial containment/narrow M-L socket for knee disarticulation	1	XXXX.XX
W6635		3	P	Ultra-light materials for KD	1	XXXX.XX
W6635		3	P	Energy-storing foot	1	XXX.XX
					TOTAL CHARGE	21 XXXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I.M. Requesting (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON

DATE

CONSULTANT ANALYST SIGNATURE